GOVERNANCE EDUCATION FOR REGIONAL HEALTH AND DEVELOPMENT

Short Title: Education for regional health and development

Abstract: Governments are advised to promote economic equilibrium, health and equity by increasing competition in centrally planned or monopolistic economic sectors, and strengthening peripheral communities. Quality management depends upon transparency, which requires separation of policy and administration with the former in the driver's seat and the latter proceeding in a spiral of steps composed of consultative planning, action and fact finding about results. Regional partnerships to plan Australian health service provision to meet community need have commenced. Effectively coordinated, high quality, flexible and cheap governance education is necessary to support these regional health and development goals. Medicare proposals to promote better care for disadvantaged groups appear productive in this context. However, many disability and mental health concerns require broader community based treatments tailored to individual and community needs. Tertiary institutions should generally encourage inquiry-based education and development approaches which critically apply national and international standards to assist regional management, including identification of those practices which seem to meet community needs best. Collegiate reform of universities is necessary to produce coordinated, transparent, and broad education for governance of services and related research, delivered under supervision in work and community settings. Education production and administration should be better designed to harness economies of scale and facilitate improved information dissemination, service outcomes, cost containment and career development. Medicare and workers' compensation fund management models may assist these governance and development objectives.

Key words: Australian health policy; health promotion; quality management; risk management; community-based rehabilitation

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A planned approach to international development and educational support

For economists with a human capital or dual market perspective, education and health are the basis of productivity. The latter group sees organisations, industries, nations and the international economy as having a central tendency towards being planned or monopolistic, and a comparatively competitive but impoverished economic periphery. There are primary and secondary labour markets related to dual development tendencies. Rural communities, subordinate cultural groups, migrants, youth, women and people with disabilities often occupy secondary labour market positions because of their comparative lack of appropriate education and work opportunities (Averitt 1968; Doeringer and Piore 1971; Gordon 1972). Governments have been advised to bring dual economies into greater equilibrium by increasing competition in centrally planned or monopolistic sectors, and strengthening communities in peripheral sectors (Galbraith 1973). Australian health and education development is addressed in this context.

Many economists (Stiglitz and Muet 1999; Sachs 2001; Stiglitz 2002) recognise the need for better world governance, including education, to manage public goods such as financial stability and environment protection. The World Health Organisation (WHO) has promoted a broadly coordinated approach to managing social administration since the Ottawa Charter stated in 1986 that necessary health supports include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity. It called for development of public policy, reorientation of health services, and community action to support health goals. Education is also necessary. The WHO program aims to increase the span of healthy life for all people in such a way that the disparities between social groups are reduced. This is consistent with prescriptions of dual labour market economists and requirements of planned regional development.

The United Nations (UN) Declaration on Environment and Development (1992) stated health concerns should lead development and the UN Commission on Sustainable Development first reviewed consumption patterns and poverty. In 2000 the Commission began to focus on sustainable land management, agriculture, finance, economic growth, trade and investment. However, the president of the World Bank recently lamented that traditional economic policies to address growth have seldom been accompanied by an equal focus on governance for health, education and environment improvement (Stiglitz and Muet 1999). Those with a narrower professional or short-term commercial focus still drive development outcomes (Stiglitz, 2002).

A holistic approach to community health must identify and prioritize community problems, in order to devise appropriate injury prevention and development programs. United Nations agencies (UN 2001) define community-based rehabilitation (CBR) as a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. This should be implemented through the combined efforts of disabled people, their families and communities, and appropriate health, education, vocational and social services. 'Community' may mean people with common interests who interact on a regular basis, or a geographical, social or government administrative unit. This rehabilitation perspective may often be manageable in a manner consistent with poverty reduction, and also assist regional planning and development on a broader basis.

Governments based on the British model have traditionally separated three principle governance powers. Elected politicians, government administrators, and the judiciary are ideally the central but independent pillars of governance in this model. They all maintain their secrets and often claim that this avoids decisional bias. In recent years transparency has become the critically different ideal of international democratic development, which is increasingly required by international trade agreements and governments. In this governance model, the emphasis is on clear separation of

policy and administration, with the former in the driver's seat (Osborne and Gaebler 1993). This is necessary to achieve the transparency required for effective public accountability and the identification of comparative service outcomes. This public interest based information ideal challenges the traditional Western model of governance and related professional development contained in silos, which Australian tertiary education was established to support.

In a quality management model of governance, independence is seen as the responsibility to make informed decisions, which can withstand public interest based scrutiny. This democratic emphasis on transparency is consistent with the economist's view that perfect information is necessary for perfect competition (Stiglitz 2002). Social administration should be envisaged as experimentation combining discovery and implementation in one process (Hart and Bond 1995). Management should proceed in a spiral of steps composed of consultative planning, action and fact finding about the results (Johnson 1997). This iterative administration and research process may then produce evidence which modifies an earlier regulatory or program direction. Contemporary health planning, health promotion, workplace risk management, action research and program budgeting ideally reflect such requirements (Eagar, Garrett and Lin 2001; National Health and Medical Research Council (NHMRC) 1995; Standards Australia 1999; Hart and Bond 1995; Wilenski 1986).

In this emerging international context, tertiary education should be broadly and consultatively planned to support effective community development, not narrower professional interests. In dual market models of education the students are potential workers and citizens, not just customers. Their contributions and career outcomes should be developed by the consumption and application of relevant knowledge and skills. The danger also must be faced that professional elites may enhance their privileges through expensive education which may be tenuously related to meeting community need, but which is required primarily for accreditation and the related monopoly of work (Blaug 1976). The quality of education needs to be judged broadly and comparatively, on the basis of

transparent education content, and the comparative outcomes of assessments which students may undertake in a variety of settings. In contrast to this developmental approach, the current university reliance on the individually presented lecture, followed by a questionnaire about student perceptions of the lecturer and subject, reveals little about the comparative quality of the educational experience.

Australia requires more transparent and more broadly consultative ways to identify community need and quality education to meet it. Ideally, traditional lecture methods should be increasingly accompanied by consistent distance or related flexible forms of education provision, which can be delivered under supervision at work or in communities. The more broadly and transparently education is coordinated and delivered, the more potential it will have to achieve the economies of scale which make its consumption cheap. The central development process should facilitate diverse but more specific education production and dissemination, which is also necessary for broad social and career development. However, it is difficult to achieve this change as long as the pursuit of individual and collegiate interests remain the central organising principles for university teaching and research. Considerable under-utilization of opportunities for continuing education has been clearly identified in Australia (Gallagher 2000; Ministerial Discussion Paper 2002). Regular performance management and development discussions which are conducted with academics appear to be an obvious avenue through which better planned approaches to education development and dissemination might be pursued by those who wish to use their competencies in the service of broader, high quality, and more equitable social outcomes.

National health and environment management supported by education

In 1990 the Council of Australian Governments (COAG) agreed to mutual recognition of state laws, and began developing national standards for health and the environment, related occupations and training, social security benefits, and labour market programs (Premiers and Chief Ministers 1991).

The governance ideal is to create a platform of national standards broadly consistent with relevant international agreements, through continuing inquiry based identification of effective practices and related harmonization of general regulation. The Competition Policy Reform Act (1995) ideally promotes competition on a national field of minimum standards related to health and environment protection. Equal competition between private and public sector providers is required unless another course of action is in the public interest (Fels 1996).

Australian health practitioners are increasingly encouraged to use evidence based approaches. These should not depend upon slavish application of approved codes of practice regardless of the evidence of needs in a specific situation. Risk management requirements of state OHS acts and professional independence are consistent. Decision makers should deviate from the approved or recommended expert practice if there is good evidence that other action appears safer in a particular context. The deviation and its justification should be recorded (Johnson 1997). Examination of documented decisions and outcomes in order to analyse, advise upon or test potential improvements in treatment is a commonly related research undertaking. However, the management of the current process of professional expenditure of Australian public and private funds requires some reform to deliver this ideal. (Review of Professional Indemnity Arrangements for Health Care Professionals 1995; Australian Health Ministers Advisory Council 1996; National Expert Advisory Group on Safety and Quality in Australian Health Care 1999).

The National Health and Medical Research Council (NHMRC 1999) statement on ethical conduct in research involving humans requires the researcher to be beneficent. This absence of a legislated duty of care for professionals exacerbates the problem that there is often no systematic approach to the collection of data about injuries, and no linkages between the compensation system, quality assurance processes, and programs or practices aimed at injury prevention. A consistent risk management approach should be taken, where appropriate, to the duties of care and disclosure

required of employers, practitioners and researchers towards workers, clients and communities. Such general duties of care and information provision would reduce pressures on researchers to hide or bend findings to suit political, commercial or other sectional forces. It would also facilitate comparison of research outcomes and promote recognition of the need for clear funding systems, harnessed in the public interest.

The National Expert Advisory Group on Safety and Quality in Australian Health Care (1999) advised that health ministers should support national actions for safety and quality related to strengthening the consumer voice and learning from incidents, adverse events and complaints. Dispute resolution services have arisen in response to the individual and public interest in fairness, maintenance of community standards and social order. From this perspective, dispute resolution should be managed as a social service, like health or education, to improve social outcomes. The National Alternative Dispute Resolution Advisory Council (NADRAC) reports to the Attorney General and seeks to assist development of the consistent definitions and requirements of mediation, conciliation and arbitration or determination which are necessary for such data driven management.

In this national context, more coordinated tertiary education provision should ideally promote regional networks of inquiry-based learning, including a consultative approach to implementation of relevant standards, and to the identification of related practices necessary to improve quality of life for particular communities and individuals. The National Expert Advisory Group called for a national effort to improve education of health care providers and advised that curricula for continuous quality improvement should be included in all undergraduate, postgraduate and continuing education. A similar approach should probably be taken across all twelve university discipline groups identified in the last federal budget. It should also capture and utilise appropriate specializations, technologies and related economies of scale in order to undertake consultatively identified curriculum production and dissemination across communities.

Development of appropriate governance education should be seen as a vital aspect of Australian economic development, which also complements the increasing international focus on opening world markets and communication technologies. It should ideally focus on promoting development and reducing inequality by meeting the diverse needs identified in multicultural, regional and remote communities, starting with the requirements of those most disadvantaged. The last federal budget introduced extra funds for regional universities and signaled teacher and nurse education as national priorities with lower student fees. Universities may now charge whatever the market will bear for their courses. Sydney University should do well from this approach. However, the current policy direction may increasingly lead to a wealthy few gaining a reproductive monopoly over professional courses where the educational fees and related specialist remuneration may be particularly high, and serve to reinforce each other, to the comparative detriment of all outside the loop.

A broader, better planned approach to education is required to reduce health, education and related community disadvantage. This should also seek to reduce the capture of the law and its public funds by any self-controlling professional elites who may have traditionally and systematically been encouraged to confuse the pursuit and reproduction of their own interests with the pursuit of the public interest. In order to pursue the public interest and the current legislated functions of universities appropriately, vice chancellors and the National Tertiary Education Union might conduct discussions within and across tertiary institutions, and also with organizations such as the National Committee on Human Rights Education Incorporated. The Committee is an independent association dedicated to promoting and extending human rights education, established with the support of business and community groups. The federal government designated the Committee as the national focal point for the UN Decade for Human Rights Education (1995-2004). Ideally, all education institutions should assist implementation of relevant international conventions and related national standards through education. To pursue related trade opportunities, vice

chancellors and a range of potential partners could also undertake discussions with ministers interested in the World Trade Organisation (WTO) General Agreement on Trade in Services (GATS). The GATS requires regular rounds of service negotiations. The Department of Foreign Affairs and Trade began this in 2001.

In all such discussions, extending the opportunities for undergraduate education should be a major priority. The private returns on investment from undertaking an Australian undergraduate degree are greater than for a postgraduate degree (Borland 2003). When a platform of transparent undergraduate education exists, the nature of the postgraduate educational requirements are less uncertain. Recognition of prior learning and improved educational articulation may all be achieved more easily. Communication technologies increasingly facilitate economies of scale in the delivery of transparent, high quality, education content in a wide variety of vocational and social contexts. The television and video cassette may now be found in homes or villages throughout the world. However, to properly harness even a small part of the enormously broad development potential of these or more expensive computer based technologies, a suitable modification of the traditional approach to working in collegiate and academic cultures is required. High level development of university, government and industry partnerships is vital to assist appropriate cooperation and specialization in the production and delivery of transparent, tertiary education content, and in related community based service or research.

Australian regional health development goals and education requirements

Australian health service developments reflect the need to promote planned service approaches, which enhance the individual's quality of life and improve community standards. In 1983 the taxpayer funded Medicare system involving free hospital care, free or heavily subsidised general practitioner care, and subsidized pharmaceuticals was established. In 1986 the Commonwealth

Disability Services Act expanded community-based services for the aged and for people with disabilities. Work related rehabilitation requirements were introduced in state workers' compensation acts to supplement injury prevention requirements of new occupational health and safety (OHS) acts. In 1988 the first national health promotion goals were established for cardiovascular disease, cancer, and injury. National programs to address mental health and the health of Aborigines were initiated. Equitable access to services, and fostering participation of communities and individuals in decision making at all levels are national health goals (Commonwealth Department of Human Services and Health 1994).

The health status of Australians measured as disability adjusted life expectancy is ranked second in the world, behind Japan (Leeder 2002). Nevertheless, between 1990 and 1998 the self-identified disability rate rose from 16% to 19% of the population. Musculo-skeletal problems comprise a third of all health difficulties experienced by around 600,000 Australians receiving the Commonwealth disability pension (Minister for Family and Community Services 1999). Around one fifth of problems are psychological or psychiatric. The likelihood of reporting disability rises with age and two thirds of those receiving a disability pension are between forty-five and sixty-five. People in rural areas are likely to have higher levels of disability.

NSW area health service managers have begun to establish regionally coordinated health management plans, with an emphasis on the needs of the aged, in consultation with their communities. An electronic health record is being constructed for everyone who accesses the national health care system. Priority health care programs are being set up for people with chronic and complex conditions (NSW Health 2000). Diagnostically related group funding systems are being developed to support hospitals and some community based services (Eager and Hindle 1995). The common requirement for service purchaser and provider splits is consistent with the view that policy and administration should be separated to identify comparative service outcomes. The NSW

disability policy framework (1998) requires a coordinated, planned and flexible approach to policy and service provision for people with disabilities and their carers. Service providers must measure and report on progress. Education for this is clearly needed.

Medicare services now allow general practitioners to focus on preventative care for older Australians and better coordinated care. Health assessments, multidisciplinary care plans and case conferences are designed to achieve a case management approach, and a better match between the services and the needs of recipients (Royal Australian College of General Practitioners 2000). Recent Commonwealth proposals seek to provide training places for more general practitioners. Incentives are proposed for doctors to locate in under-serviced rural areas and bulk bill Medicare when providing free consultations to comparatively disadvantaged people, identified primarily by their status as Commonwealth concession card holders. The government estimates these payments would mean $1 extra for the doctor per concessional service in capital cities, up to $6.30 per concessional service in rural or remote areas. Funding is proposed to assist general practices upgrade computer links with the Health Insurance Commission, and to enable up to eight hundred practices to receive assistance in employing a nurse or other allied health care worker. Participating doctors must agree to provide services at no cost to patients covered by a concession card (Commonwealth Department of Health and Ageing 2003). Critics argue that the proposals will encourage higher fees for non-concessional patients. The government denies this, and states that no proposals are compulsory. Doctors will choose whether to access offers and whether they will continue to bulk bill all their clients, or require additional payments.

Such proposals might help address the relationship between poverty and poor health, which exists in Australia as well as internationally. However, many people in comparatively disadvantaged communities may primarily require better housing, care, education, recreation, transport or related family and vocational support to improve their mental health and reduce their disabilities. For

example, the young, troubled, poor and Indigenous experience a comparatively high risk of accidental injury, depression, anxiety, self harm, victimization and imprisonment (Australian Institute of Health and Welfare 2000; Australian Bureau of Statistics 1997, 2001; Standing Committee on Law and Justice 2000). In 1996 the World Health Assembly established violence prevention as a health priority. Australia now addresses interpersonal violence within the national injury prevention program (McDonald 2000). In NSW the Attorney General can provide local councils with funding for crime prevention programs which are planned and implemented with communities. NSW housing policy attempts to provide subsidized housing, which promotes socio-economic mix as a crime prevention and employment strategy. The introduction of the NSW Victims Compensation Act and the Young Offenders Act provide potential for studying the comparative effects of court diversionary practices and jail on community health and crime.

Debate continues about how best to develop better coordinated regional management approaches to improve individual and community health. The NSW Families First program offers a point of contact with infants and their families which may also become an appropriate opportunity to provide a range of related support, in cooperation with hospitals, general practitioners, child care facilities, schools and tertiary institutions. The UN CBR statement stresses that improving the capacity and skills for community involvement is important and must be coordinated to ensure optimum use of resources. CBR workers should be taught to provide client support and flexible service management to meet identified regional needs. Coordinated health and crime prevention strategies should also provide for education which supports student and community development through assisting mentoring and related care, recreation, social or vocational development for high-risk individuals and communities. Planning and implementing these strategies might be undertaken through partnerships between general practitioners, elected community representatives, educational institutions, community centres, police and Centrelink offices, as well as programs such as NSW Families First. Students and communities would benefit from broadly coordinated work and

community based education placements, which might also assist program implementation and related research. The Australian Research Alliance for Children and Youth appears to be an appropriate national organisation to advise upon such matters.

Education and research to support regional development

Because of their legislated functions, holistic range of expertise and independence, Australian universities potentially appear to be appropriate leaders of planned education and research programs necessary to support effective regional development. All but two of thirty-nine universities are established under state legislation, which requires they have education, research, community service and certification as major functions. However, around 60% of university funding comes from the Commonwealth, and universities are bound by its administrative requirements. The review of higher education financing and policy (1997) noted that universities must address a range of related problems, which arise as a result of the expectation for traditional collegiate decision making. A Senate references committee (2001) also discussed the major limitations imposed on effective development by collegiate governance structures, and the need to identify alternate funding models that would better serve the needs of regional and disadvantaged students. A ministerial discussion paper (2002) quoted the views of independent auditors that the current state of cost management in most universities is not adequate to support the needs of their businesses and the changing landscape.

Governments currently appear unprepared to address community needs for transparency, which may conflict with protection of intellectual property or related professional interests. One risk of this is that academics will increasingly dance to any piper's tune, as long as they are paid. On the other hand, a 2002 conference of the Medical Foundation and College of Health Sciences of Sydney University defined 'commercialization' as 'the process of transferring research outcomes to the community in a manner which optimises the chances of their successful implementation, encourages

their use, accelerates their introduction and shares the benefits among the contributing parties'. This definition potentially coordinates inconsistent commercial, government, and collegiate objectives more effectively. Although it has no legislative backing, any organization might adopt it contractually to facilitate a more rational approach to educational production, dissemination, service delivery and research which is also designed to enhance healthy development through transparent, consultative and evidence based approaches to solving community problems.

Australian tertiary education should be managed so as to encourage development of vocational modules designed to meet international goals related to health and sustainability, which can also be made cheaply and flexibly available to all who can benefit. Education content, delivery and assessments should be designed to assist identification, prioritization and control of health risks at work and in communities in order to promote healthy and diverse development as broadly and equitably as possible. A consistently developed and increasingly diverse range of transparent education products and delivery options are necessary which can meet the need for effectively articulated and flexible career development within a global context. This depends partly upon industry, community and collegiate recognition of opportunities where substantial economies of scale can be utilised in the production and delivery of education at home and abroad. Planning should focus on services to improve the health and environment of comparatively powerless groups, such as children, people with disabilities, and the poor. This might assist regional development of related strategic research. Such an education and research model should also help communities and individuals to implement regional, national and international goals and environment standards in a more informed and independent manner.

The NHMRC statement on ethics in research involving humans (1999) claimed it is difficult to find an agreed definition of research. However, the Health and Medical Research Strategic Review (1997) thought that Australia should develop a focus on the prioritized creation and assessment of

interventions and policy. Adopting definitions from the WHO the report stated the national research effort should take three forms. Fundamental research should generate knowledge about problems of scientific significance. Strategic research should generate knowledge about specific health needs and problems. Research for development and evaluation should create and assess products, interventions and instruments of policy that seek to improve on existing options. This is consistent with requirements of effective regional management, and also with the Boyer (1990) model of scholarship. The latter seeks to integrate teaching and research activities, and distinguishes between four forms of scholarship. Discovery creates new knowledge. Integration puts it in an intellectual context. Application applies it in useful ways for individuals, industry and institutions. Teaching ideally facilitates student learning and developing scholars in all these areas.

Towards national structures for better regional fund management

Regional implementation of national health goals should assist development of coordinated, consultative, flexible and effective approaches to all service provision and related fund management, including education. Kendig and Duckett (2002) have proposed that all Commonwealth and state funds for aged care services should be pooled into a single regionally managed fund. They recommend that housing and aged care should be funded separately, with streams for accommodation on one hand, and for living costs and care needs on the other. Care provision based on identified personal needs should apply the current resident classification system for the elderly, irrespective of whether services are provided in residential care or the home. A suitably coordinated approach should be investigated in related education and service areas. Medicare and workers' compensation risk management and investment models may also be appropriate for wider application. Education and research need to be consultatively considered in this context.

Russian and Chinese experience suggests that stable management and competition are more important than private property for effective functioning of the market (Stiglitz and Muet 1999; Stiglitz, 2002). Duckett (1997) found that on social indicators related to access, equity and cost, the Australian Medicare system outperforms U.S. health care, which is privately funded through employment related or family health insurance. Australian Medicare pricing requirements also put downward pressure on private provider prices. Critics of increased government contracting (Hancock 1999; Smyth and Cass 1998) ignore the relationship these initiatives may bear to national and state regulatory processes which have progressively extended government and industry ownership of health, workers' compensation and retirement funds over the past two decades. Funds are managed competitively by the private sector, but this occurs according to requirements established by government and industry. Premium holders and those injured are the primary stakeholders in this model (Heads of Workers' Compensation Authorities 1997).

Such insurance schemes ideally are designed to extend public and industry ownership and control over funds, which were formerly privately owned and commercially driven, supposedly in the interests of all shareholders. The Australian insurance experience clearly shows that private sector underwriting and competition on premium price inhibits effective injury prevention, rehabilitation, fund management and containment of cost. (NSW WorkCover Review Committee 1989; House of Representatives Standing Committee on Transport, Communications and Infrastructure 1992; Review of Professional Indemnity Arrangements for Health Care Professionals 1995; Australian Health Ministers Advisory Council 1996; Standing Committee on Law and Justice 1997; Industry Commission, 1997; The HIH Royal Commission 2003). Private sector insurance practice is not transparent, and premium price competition promotes economic instability. Private underwriters require high profit margins to guard against the effects of competitive premium price cutting, global economic fluctuations, unexpected court awards or long tail claims, poor investment decisions and

inefficient administration practices. Nevertheless, these factors often produce insurer insolvencies, often at great cost to the public purse.

When the national premium pool is broken up and owned by competing insurers, they require international reinsurance and high profit margins to guard against insolvency. The cost of this is passed on to the community of premium holders. On the other hand, when funds are owned by government and industry, and when premiums and benefits are established by legislation, the insurers contracted to manage the system may be encouraged to compete for market share by providing premium holders with risk management and investment services, rather than premium price cuts. Benefits of managed fund investments return to scheme stakeholders rather than insurance company shareholders. The comparative practices and outcomes of all competing service providers, including those in education, may be more easily evaluated in a legislative model which values transparent, contractually defined, service development and delivery undertaken through stakeholder management of pooled regional funds which are broadly owned and conservatively invested in the community and individual interest.

Conclusion

Economists draw attention to the tendency for dual market development and the need for governments to promote competition in monopolistic sectors of the economy and more planned development in disadvantaged peripheries. A broadly coordinated and transparent approach to regional health, education and research is necessary to support this vision. The Australian health industry has begun this. However, community health problems often require broad, individually tailored, community based rehabilitation and development strategies rather than a medical model of treatment. Communities also require appropriately coordinated, transparent, high quality, cheap educational product which can be flexibly delivered to assist their development. The maximisation

of opportunities for providing this depends upon collegiate, government and community recognition of the need for university reform. Tertiary education institutions should encourage development of vocational modules and research designed to meet international and local community health and sustainability goals, through the academic performance management and development process. Better utilization of provider specialization in education production, combined with economies of scale in subject delivery, would allow tertiary institutions to teach and accredit an increasingly wide and diverse range of product and performance. Proposals that funds for aged care services should be regionally pooled appear relevant for other service provision, including education. Medicare and workers' compensation insurance may also provide useful risk management and investment models for consideration in a context where students are ideally educated within a much broader community.

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